GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HEALTH
HEALTH REGULATION ADMINISTRATION

HEALTH CARE
FACILITIES
DIVISION

PHONE: 202-442-5888
FAX : 202-442-9430

MAILING ADDRESS:

825 North Capitol Street,N.E.
2nd Floor
Washington, D. C. 20002

APPLICATION FOR HEALTH CARE FACILITY LICENSE

Any person (s) desiring to operate a health care facility in the District of Columbia must complete this form and return it to the Department of Health. The form must be completed in its entirety.

Return Application to:

Administrator
Health Regulation Administration
825 North Capitol Street, NE 2nd Floor
Washington, DC 20002

IDENTIFYING

A. APPLICANT: If the applicant is a corporation or association complete the information item for each officer and director.

PART I

1. Name_____ 2. Age_____

3. Address _____4. Phone _____

4. Occupation_____ 5. Phone #_____

Name_____ Age_____

Address: _____

Occupation_____Phone #_____

Name_____Age_____

Address_____

Occupation_____Phone #_____

Name_____Age_____

Address_____

Occupation_____Phone #_____

B. **FACILITY ADMINISTRATOR: This information pertains to the individual designated by the applicant as the Administrator of the facility.**

Name_____ **Age**_____

Address_____

Occupation_____ **Phone** _____

Other Pertinent Information_____

C. **FACILITY: This information pertains to the premises which are to constitute the health care facility.**

1. **Name**_____
2. **Address**_____
3. **Description of all structures and facilities which comprise the premises (attach additional pages if necessary)**_____
_____

4.	**a. Type**	**b. Distinct Part**	**c. Beds**
	[ ] Skilled Nursing	**[ ]**	_____
	[ ] Nursing Facility Care	**[ ]**	_____

If application is for distinct part certification, attach a list showing number of beds by room number for each distinct part.

5. **Certificate of Occupancy #** _____

OWNERSHIP INFORMATION

District of Columbia regulations require full and complete ownership information and prompt reporting of any and all changes which affect accuracy of this information.

PART II **A.** **Type of Organization**

[ ] sole proprietorship
[ ] non-profit corporation
[ ] corporation for profit
[ ] partnership
[ ] other - specify
_____

1. _____
Jurisdiction of Corp.
2. _____
IRS Exemption Cert. #
3. _____
Social Security #
4. _____
Employers ID. #

B. **Mandatory Insurance Coverage: [ ]yes [ ]no**

TYPE	**COMPANY NAME**	**POLICY NUMBER**
_____	_____	_____
_____	_____	_____
_____	_____	_____

C. **List name of each person having a direct or indirect interest of 1% or more in the facility, corporation operating the facility, or who is owner (in whole or in part) of any mortgage, deed, or trust, note, or other obligation secured (in whole or in part) by the facility or any property or assets of such facility:**

Name_____

Address_____

Name_____

Address_____

Name_____

Address_____

Name_____

Address_____

Name_____

Address_____

D. **If the facility is organized as a corporation, list name and address of each officer and director of the corporation. Provide a Certificate of Corporation in Good Standing.**

Name_____

Address_____

Name_____

Address_____

Name_____

Address_____

Name_____

Address_____

Name_____

Address_____

E. **If the facility is organized as a partnership, list name, and address of each partner.**

Name_____

Address_____

Name_____

Address_____

Name_____

Address_____

Name_____

Address_____

Name_____

Address_____

F. **List the name, address, and occupation of individuals not identified in items D, and E, who will be entitled to receive directly or indirectly through design or assignee, any pecuniary profit from the operation of the home, other than compensation for services rendered.**

Name_____**Occupation**_____

Address_____

Name_____**Occupation**_____

Address_____

Name_____**Occupation**_____

Address_____

Name_____**Occupation**_____

Address_____

Name_____**Occupation**_____

Address_____

LICENSURE
PART 111

1. Type of License

[ ]Skilled ____beds
[ ]Nursing Facility____beds
[ ]Other _____ beds

2. Have you ever had a license to operate a convalescent and/or personal care home?
[ ] yes [ ] no

3. Have you ever been denied a License? [ ] yes [ ] no
If yes, indicate when

_____ ____ ____
Month Day Year

4. Name(s) of Licensed Administrator(s)
_____
_____

5. Administrator(s) License Number(s)
_____
_____

6. Hours on Duty/week
_____
_____

TRANSFER AGREEMENTS

Facility has a written agreement in effect with a hospital for transfer of patient medical and other information between the institutions.

PART IV

1. [ ] yes (list)
_____
_____
_____

2. [ ] no (If no, attach statement) _____

3. [ ] Negotiations in process

SERVICES PROVIDED

PART V

Identify below all services provided by the facility. Write a (D) by each service that is provided directly and a (C) by each service provided by contract with outside resource.

1. [ ] Nursing	**8. [ ] Clinical Lab.**
2. [ ] Physical Therapy	**9. [ ] Diagnostic x-ray**
3. [ ] Occupational Therapy	**10. [ ] Dentistry**
4. [ ] Speech Therapy	**11. [ ] Podiatry**
5. [ ] Social Services	**12. [ ] Ophthalmology**
6. [ ] Recreational Therapy	**13. [ ] Dietary**
7. [ ] Pharmacy	**14. [ ] Other:**

_____

_____

EMPLOYEE INFORMATION

PART VI

Enter the number of persons employed by the facility according to profession.

	Total
1. Registered Nurses	_____
2. Licensed Practical Nurses	_____
3. Licensed Physical Therapists	_____
4. Qualified Speech Therapists	_____
5. Licensed Occupational Therapists	_____
6. Licensed Pharmacists	_____
7. Licensed Social Workers	_____
8. Other Social Work Personnel	_____
9. Medical Records Practitioners	_____
10. Licensed Dietitians	_____
11. Other	_____

PHYSICIAN SERVICES

Name of Principal Physician or Medical Director

PART VII

PART VIII

<u>All statements are true.</u> (Other reasonable information which is required in order to ascertain the ability to operate a health care facility in conformity with DCMR 22 "Public Health and Medicine" be made available upon request. In addition, any changes in the facts stated in this application will be transmitted to the Department of Health within ten (10) days of the change).

SIGNATURE(S)	TITLE	DATE
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

In the case of an individual ownership, the signature is that of the individual; if a partnership, the signature is that of all partners; if a corporation, the signature is that of two (2) of the Officers, one of whom is the President.

PART IX **Attach application together with a Check or Money Order made PAYABLE TO THE D. C. TREASURER.**

PAY THIS AMOUNT $_____

License fees for nursing homes are as follows:

(a) 1-50 beds
Annual Fee $390
Late Fee $195

(b) 51-100 beds
Annual Fee $520
Late Fee $260

(c) 101 or more beds
Annual Fee $650
Late Fee $325

YOU CAN HELP ELIMINATE FRAUD, WASTE, ABUSE AND MISMANAGEMENT IN THE DISTRICT GOVERNMENT BY REPORTING VIOLATIONS TO THE OFFICE OF THE INSPECTOR GENERAL BY CALLING HOTLINE (202) 727-2540. ALL CALLS ARE CONFIDENTIAL.